

Field Advisory Services - *FAS*
Benefits & Entitlements Branch
Disability Medical Documentation
Aids for Specific Conditions

The Benefits and Entitlements Branch of the Field Advisory Services Division, Department of Defense (DoD), in cooperation with the Office of Personnel Management (OPM), have prepared the attached “Disability Information Sheet(s)”. We encourage employees and their treating physicians to use these sheets to help them with the medical documentation needed to support the employee’s application for disability retirement.

One of the criteria to qualify for disability retirement is the presence of a medical condition. OPM defines medical condition as a disease or injury. The terms listed on the Information Sheet(s) can help the employee and his/her physician(s).

We hope the Information Sheet(s) will help avoid delays in OPM’s processing of an application that can result when medical documentation is needed. The sheets are simply an aid; using them does not guarantee approval of any application but should help the employees and doctors in documenting the medical condition of the employee. Feel free to add any additional pages to document your disability.

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DISABILITY INFORMATION SHEET FOR ALLERGIES

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ When did the symptoms begin? Describe their nature, please.

_____ Did the symptoms develop after starting a new job or after new materials were introduced?

_____ Did the symptoms develop within minutes of specific activities or exposure at work?

_____ Is there a history of a high level acute exposure?

_____ Do delayed symptoms occur? Describe, please.

_____ Do symptoms occur less frequently or not at all on days away from work and on vacation?

_____ Do symptoms occur more frequently on returning to work?

_____ Any history of atopy? Describe.

_____ Smoking history?

_____ Occupational history?

_____ Have the following other clinical disorders been excluded?

_____ Autoimmune disease?

- _____ Infectious disorders?
- _____ Psychiatric disorders?
- _____ Chronic inflammatory disorders?
- _____ Endocrine disorders?
- _____ Intoxications?
- _____ Side effects of medications?
- _____ Drug dependency? (Please describe in some detail for each condition.)

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the respiratory and nervous systems.

LABORATORY STUDIES: (If performed)

- _____ Dynamic pulmonary function tests with and without bronchodilator?
- _____ Static pulmonary function tests including DLCO.
- _____ Inhalation challenge testing?
- _____ Results of skin testing?
- _____ RAST tests?
- _____ Results of peak expiratory flow rates while at work and away from work.
- _____ Copies of MSDS for substances used at work?
- _____ Results of recent industrial hygiene surveys for the work place.
- _____ CBC?
- _____ Sedimentation rate?

_____ X-rays?

_____ ANA?

_____ PPD?

_____ Serum electrolytes/glucose; creatinine and blood urea nitrogen; calcium & phosphorus; alkaline phosphatase and total bilirubin; serum aspartase serum aspartase aminotransferase; serum alanine aminotransferase; creatine phosphokinase?

_____ Urinalysis? (Please provide copies of reports.)

THERAPY:

_____ Medications?

_____ Other treatment?

_____ Immunotherapy?

_____ Respirator use?

_____ Restrictions? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR APNEA & NARCOLEPSY

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ When did symptoms begin?

_____ Is there heavy snoring?

_____ Is snoring intermittent with periods of respiratory silence?

_____ Is there motor restlessness?

_____ Is daytime somnolence present?

_____ Headaches?

_____ Depression?

_____ Is the patient taking drugs which may cause this problem such as hypnotics?

_____ Is alcohol use common before bedtime?

_____ Does sleep partner complain of snoring or describe other symptoms?
(Please describe.)

_____ Family history of sleep disorders?

_____ Does patient have Down's syndrome acromegaly, myxedema, or upper or lower respiratory disease?

_____ History of sudden, brief sleep attacks?

- _____ Cataplexy?
- _____ Sleep paralysis?
- _____ Hypnagogic hallucinations?

PHYSICAL EXAMINATION:

- _____ Height and weight.
- _____ Is neck short and obese?
- _____ Is there tonsillar or adenoidal hypertrophy?
- _____ Is there narrowing of the pharynx?
- _____ Are vocal cords normal?
- _____ Blood pressure?
- _____ Is there evidence of neurological deficit?

LABORATORY STUDIES: (If performed)

- _____ Sleep studies?
- _____ Do these show an excessive number of periods of arousal or other sleep disturbance?
- _____ Is sleep latency normal?
- _____ Evidence of oxygen desaturation of arterial blood?
- _____ Arrhythmias or bradycardia or other cardiac abnormalities?
- _____ Motor restlessness?
- _____ HLA?
- _____ DR2?

_____ EEG?

THERAPY: (Please also describe patient compliance and response to therapy)

_____ Weight loss?

_____ Uvulopalatoplasty or palatopharyngoplasty or other surgery?

_____ Continuous positive airway pressure?

_____ Tracheostomy?

_____ Have any other diseases which may contribute to this condition been treated fully?

_____ Other?

_____ Medications? (Please describe.)

DISABILITY INFORMATION SHEET FOR ASTHMA

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy on this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain information from your treating physician(s). Specific information may be needed regarding:

HISTORY

_____ When did the respiratory symptoms begin?

_____ Dyspnea? (Time of day, how many blocks can be walked, how many stairs can be climbed, etc.)

_____ Frequency of asthmatic attacks?

_____ Frequency and nature of respiratory infections?

_____ Cough? (Productive or non-productive, time of day, etc.)

_____ Wheezing? (Time of day, week, etc.)

_____ Frequency of episodes of asthma requiring hospitalization or emergency treatment?

_____ Allergic history?

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the respiratory system.

LABORATORY: (If performed)

- _____ When did the respiratory symptoms begin?
- _____ Cough? (Productive or non-productive, time of day, etc.)
- _____ Dyspnea? (Time of day, how many blocks can be walked, how many stairs can be climbed, etc.)
- _____ Wheezing? (Time of day, week, etc.)
- _____ Frequency of asthmatic attacks?
- _____ Frequency and nature of respiratory infections?
- _____ Allergic history?
- _____ Frequency of episodes of asthma requiring hospitalization or emergency treatment?
- _____ Dynamic pulmonary function tests with and without bronchodilators?
- _____ Static pulmonary function tests including DLCO.
- _____ Inhalation challenge testing?
- _____ Results of skin testing?
- _____ RAST tests? (Please provide copies of reports.)
- _____ Results of peak expiratory flow rates?

THERAPY:

- _____ Medications?
- _____ Immunotherapy?
- _____ Respirator use?
- _____ Restriction? (Please describe.)
- _____ Response to therapy.

DISABILITY INFORMATION SHEET FOR CARDIAC DISEASE

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ Dyspnea? (Whether at rest and/or on exercise, how many blocks can be walked, how many stairs walked up, orthopnea?)

_____ Palpitations, irregular pulse, arrhythmias?

_____ Edema of the feet, ankles, legs?

_____ Dizziness, fainting?

_____ Cough? (sputum production, hemoptysis, etc.)

_____ Smoking history (How many years? How many packs per day?)

_____ Chest pain? (where, when, what makes it worse or better, etc.)

_____ New York Heart Association Classification?

_____ Other? (Please describe in detail.)

PHYSICAL FINDINGS:

_____ Lung examination? (rates, rhonchi, loss or decrease in breath sounds)

_____ Heart examination? (size, apical impulse, rate, rhythm, character of sounds, murmurs)

_____ Blood pressure?

_____ Thrills, carotid bruits, jugular vein distension?

_____ Edema of the feet, legs?

_____ Cyanosis?

_____ Other? (Please describe in detail?)

LABORATORY STUDIES:

_____ Electrocardiogram?

_____ Scintigraphy, MUGA scans?

_____ Exercise testing?

_____ Enzymes?

_____ Catheterization?

_____ Echocardiogram?

_____ Holter monitoring?

_____ Chest X-ray?

_____ Coronary arteriogram?

_____ Other? (Please describe in detail.)

THERAPY: *(Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.)*

_____ Medications?

_____ Operative summaries?

_____ Physical therapy, exercise training?

_____ Restrictions?

_____ Cardiac pacing?

_____ Please explain the physiologic basis for the restrictions?

_____ Summaries of hospitalizations?

_____ Other? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR CARPAL TUNNEL SYNDROME (CTS)

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy of this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ Nature and location of current symptoms, e.g. pain, numbness, paresthesia, weakness, clumsiness, etc.? (Please describe in detail.)

_____ If there is pain, does it radiate proximally and, if so, to where?

_____ Is the patient awakened by the pain?

_____ What activities aggravate or produce symptoms and which alleviate symptoms?

_____ Is there a history of repetitive use of the hands?

_____ Any family history of CTS?

_____ Any history of diabetes, rheumatoid arthritis, amyloidosis, sarcoidosis, hyperparathyroidism, myxedema, trauma to the hand or wrists, etc?

PHYSICAL EXAMINATION:

_____ Describe the areas of pain or tenderness?

_____ Any deformities?

_____ Any changes in sensation to pinprick, two point discrimination and vibration? (Please describe the distribution.)

_____ Any thenar atrophy?

_____ Any motor weakness? (Please describe.)

_____ Finklestein's Sign?

_____ Tinel's Sign?

_____ Phalen's Sign?

LABORATORY STUDIES:

_____ EMG/NCV?

_____ Sedimentation Rate?

_____ ANA?

_____ Rheumatoid factor?

_____ X-rays?

_____ MRI?

_____ Etc? (Please provide copies of reports.)

THERAPY: (Please describe in detail).

_____ Medications?

_____ Splints?

_____ Steroid injections?

_____ Physical therapy?

_____ Describe changes that have been made in the work place such as tilting of work surface, keyboard, display terminal, hand or arm rests; changes in tool design or arrangement, changes in the frequency of the repetitive cycle, etc?

_____ Please describe any restrictions that have been imposed.

DISABILITY INFORMATION SHEET FOR CHRONIC FATIGUE SYNDROME

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ Date of onset of fatigue?

_____ Severity?

_____ History of low grade fever?

_____ Sore throat?

_____ Painful lymph nodes?

_____ Muscle weakness?

_____ Myalgias?

_____ Headache?

_____ Sleep disturbances?

_____ Arthralgias?

_____ Neuropsychologic complaints?

_____ Fibromyalgia?

_____ Adequately treated toxoplasmosis, brucellosis, or Lyme borreliosis?

_____ Nonpsychotic depression, somatoform disorders, generalized anxiety or panic disorders?

_____ If psychiatric disease is present, has it been treated and, if so, have CFS symptoms abated along with other symptoms?

_____ Have the following other clinical disorders been excluded?

_____ Autoimmune disease?

_____ Chronic active hepatitis B or C?

_____ Inadequately treated Lyme borreliosis?

_____ HIV infection?

_____ Tuberculosis?

_____ Other infectious disease?

_____ Psychotic depression, bipolar disorder, or schizophrenia?

_____ Substance abuse?

_____ Malignancy?

_____ Chronic inflammatory disorders?

_____ Neuromuscular diseases?

_____ Endocrine disorders?

_____ Intoxications? (Please describe in some detail for each condition.)

PHYSICAL EXAMINATION:

_____ Fever? (Please provide serial AM and PM temperature measurements.)

_____ Non-exudative pharyngitis?

_____ Palpable and/or tender cervical nodes?

_____ Weight, measured serially?

_____ Results of a complete current physical examination?

LABORATORY STUDIES:

_____ Blood work? Complete blood count and differential; serum electrolytes; glucose; creatinine; BUN; calcium; phosphorus; total bilirubin; alkaline phosphatase; serum aspartate aminotransferase; serum alkaline aminotransferase; creatine phosphokinase or aldolase; erythrocyte sedimentation rate; antinuclear antibody; thyroid stimulating hormone?

_____ HIV antibody measurement?

_____ Intermediate strength PPD?

_____ X-rays?

_____ Urinalysis?

_____ Neuropsychological testing?

_____ Other tests to rule conditions listed under the history?

THERAPY:

_____ Medications?

_____ Other treatment? (Please describe in detail.)

_____ Hospitalizations? (Please provide summary.)

DISABILITY INFORMATION SHEET CUMULATIVE TRAUMA INJURY

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ When did the symptoms begin? Describe the nature, location and severity of symptoms.

_____ Are there paresthesia?

_____ Where? What activities help and which aggravate the symptoms?

_____ Does the patient's job require: frequent repetitive use of the same or similar movements of the affected joints(s) or anatomic area?

_____ Maintaining force with the hand(s) at or above the shoulder level?

_____ Regular or sustained task in awkward position?

_____ Regular use of vibrating tools or prolonged pressure over the wrist or palm?

_____ Frequent or continuous exposure to cold air or gripping cold tools, hand controls, equipment, etc?

PHYSICAL EXAMINATION:

_____ Describe the areas of pain or tenderness.

_____ Are any deformities noted? Describe the range of motion of the affected parts in degrees.

_____ Is muscle spasm present?

_____ Is there any crepitance, effusion of soft tissue swelling? Describe muscle power.

_____ If weakness is present, is it of the "give way" or "voluntary release" type?

_____ Is there any evidence of muscle atrophy?

_____ Neurological examination as appropriate (sensation, vibration, heat, cold, Tinel's sign, Phalen's sign, shoulder abduction test, etc.).

LABORATORY STUDIES:

_____ Please include copies of reports. X-rays, MRI, CT Scan, Bone Scan, EMG, NCV?

_____ ANA, sedimentation rate rheumatoid factor, etc.?

THERAPY:

_____ Splints, braces or other supports?

_____ Medication?

_____ Physical therapy?

_____ Exercises? (Describe in detail)

_____ Hospitalizations or operations (Provide copies of summaries)?

CHANGES IN THE WORK PLACE:

_____ What changes have been made to reduce postural strain (decreased reach, height of chair or work surface, tilting of work surface, keyboard, hand or arm rests, etc.?)

_____ What changes have been made to tool design or arrangement?

_____ Could power tools be used instead of hand tools?

_____ Have changes been made in the frequency of the repetitive cycle?

DISABILITY INFORMATION SHEET FOR DIABETES

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ How long has the disease been present?

_____ Visual symptoms?

_____ Frequency and severity of the episodes of ketoacidosis and/or hypoglycemia?

_____ Parasthesias or other symptoms of neuropathy?

_____ Claudication, angina, MI's, strokes, small vessel disease, etc.?

_____ Skin problems (e.g. pruritus, infections, gangrene, etc.)?

_____ Does the patient routinely monitor glucose levels?

_____ Diarrhea, constipation, postural hypotension, urinary retention, etc.?

_____ Other? (Please describe).

PHYSICAL FINDINGS:

_____ Weight?

_____ Eye and fundoscopic examination?

_____ Blood pressure?

_____ Peripheral pulses?

- _____ Pulse?
- _____ Capillary refill time?
- _____ Complete neurological examination?
- _____ Skin ulceration infections, etc.? (If present, size, location, etc.)
- _____ Other? (Please describe).

LABORATORY STUDIES:

- _____ Fasting and postprandial plasma glucose levels?
- _____ EMG's/Nerve conduction velocity?
- _____ Glucose tolerance test?
- _____ Bladder function?
- _____ Cholesterol?
- _____ Arteriogram?
- _____ Other blood lipids?
- _____ Doppler testing of the peripheral circulation?
- _____ Electrocardiogram?
- _____ Ophthalmological examinations?
- _____ Tests of renal function? (i.e. BUN, Creatinine, Albuminuria, urine specific gravity, etc.)
- _____ Radiographs of the chest, abdomen, extremities, etc.?
- _____ Glycohemoglobin?
- _____ Other? (Please describe).

THERAPY: *Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.*

_____ Weight reduction?

_____ Other treatment modalities?

_____ Diet?

_____ Exercise?

_____ Oral hypoglycemic agents?

_____ Hospitalization(s)? (Please include reports.)

_____ Insulin (What type, how much, and how frequently)?

_____ How well controlled is the diabetes?

_____ Restrictions?

_____ Other? (Please describe).

DISABILITY INFORMATION SHEET FOR DYSTROPHY

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Location and nature of the pain?

_____ Duration of pain?

_____ History of trauma? (Please describe).

_____ History of any psychiatric disorders?

PHYSICAL EXAMINATION:

_____ Any skin changes, e.g. cold, cyanotic, sweaty or warm, dry and red, etc.?

_____ Increased or decreased hair growth?

_____ Changes in nail growth, e.g. split or ridged, etc.?

_____ Range of motion of the affected joints (both active and passive).

_____ Any atrophic skin changes?

_____ Edema? (Please describe).

_____ Any muscle atrophy?

_____ Any tapering of digits?

LABORATORY STUDIES: (If performed)

_____ Skin temperature?

_____ Thermography?

_____ Skin blood flow?

_____ Sweat tests?

_____ X-rays?

_____ Bone scans?

_____ Etc.? (Please provide copies of reports).

THERAPY:

_____ Oral medications? (Please describe).

_____ Physical therapy?

_____ Sympathetic blockade? (Please describe the response).

_____ Surgical sympathectomy?

_____ Etc.?

DISABILITY INFORMATION SHEET FOR EOSINOPHILIC MYALGIA SYNDROME

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Date of onset of symptoms?

_____ Nature of symptoms? (Please describe in detail)

_____ Myalgia?

_____ Arthralgia?

_____ Dyspnea?

_____ Cough?

_____ Rashes? (Please describe in detail)

_____ History of L Tryptophan ingestion? When and for how long?

_____ Other symptoms?

PHYSICAL EXAMINATION:

_____ Edema? (Describe in detail)

_____ Fever?

_____ Skin changes? (Please describe in detail)

_____ Hair loss?

_____ Sensory changes? Describe in detail.

_____ Other? (Please describe).

LABORATORY STUDIES: (If performed)

_____ CBC?

_____ EMG/NCV?

_____ Pulmonary Function studies?

_____ Chest X-rays?

_____ Sedimentation rate?

_____ ANA?

_____ Creatine Kinase?

_____ Liver function studies?

_____ Liver biopsies? Please provide copies of all reports.

THERAPY:

_____ Medications? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR ESOPHAGITIS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Pyrosis? (Please specify the severity).

_____ When does it occur?

_____ What's the temporal relationship to eating?

_____ Effects of recumbency and of sitting upright?

_____ Any radiation of the pain? If so, where? (Please specify).

_____ History of nausea and/or vomiting?

_____ History of water brash?

_____ Hoarseness? (Please describe).

_____ Globus?

_____ Dysphagia?

_____ Hematemesis?

_____ Melena?

_____ Anemia?

PHYSICAL EXAMINATION:

_____ Results of a complete physical examination with emphasis on the abdomen.

_____ If there is significant laryngeal involvement, please include findings pertaining to the head and neck.

_____ Height and weight?

LABORATORY STUDIES: (If performed)

_____ Upper GI series?

_____ Barium swallow?

_____ Acid perfusion test?

_____ Endoscopy?

_____ Esophageal Ph monitoring?

_____ Biopsy?

_____ Evaluations by speech pathologists if hoarseness is present. (Please provide copies of reports).

THERAPY:

_____ Medications? (Please specify).

_____ Diet modification?

_____ Tobacco and alcohol abstinence?

_____ Weight reduction if indicated?

_____ Elevation of the head of the bed?

_____ Speech therapy?

_____ Other? (Please specify).

DISABILITY INFORMATION SHEET FOR EYE DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

- _____ When did visual symptoms first develop?
- _____ Any changes in visual acuity?
- _____ When was it first noted?
- _____ Any photophobia?
- _____ Any halos or rings around lights?
- _____ Any difficulty seeing in the dark?
- _____ Any momentary loss in vision? (Describe in detail, please.)
- _____ Any pain in eye(s)?
- _____ Headache?
- _____ Any swelling or redness of eyes?
- _____ Discharge (Describe, please.)
- _____ Diplopia?
- _____ Vertigo?
- _____ Increased or decreased lacrimation?

PHYSICAL EXAMINATION:

- _____ Visual acuity, far and near, corrected and uncorrected?
- _____ Condition of external ocular structures?
- _____ Pupillary size, shape and reaction to light and accommodation, etc.?
- _____ Size, prominence, and position of eyes?
- _____ Strabismus?
- _____ Nystagmus?
- _____ Visual fields by confrontation?
- _____ Extraocular motion?
- _____ Fundoscopic examination?

SPECIAL STUDIES: (If performed)

- _____ Slit lamp examination?
- _____ Perimetry?
- _____ Tonometry?
- _____ Gonioscopy?
- _____ Keratometry?
- _____ Ophthalmoscopy?
- _____ Fluorescein angiography?
- _____ Toxoplasmosis antibody tests?

THERAPY:

_____ Medications?

_____ Corrective lenses?

_____ Surgery? (Please provide copies of operative reports.)

_____ Hospitalizations? (Please provide copies of discharge summaries.)

DISABILITY INFORMATION SHEET FOR FIBROMYALGIA

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Location of pain? (Please describe in detail)

_____ Nature and duration of pain(s).

_____ Any stiffness? (When is it most pronounced and how long does it last?)

_____ What exacerbates symptoms and what helps them?

_____ Fatigue?

_____ Tiredness?

_____ Chronic headaches?

_____ Quality of sleep?

_____ Subjective swelling?

_____ Numbness?

_____ Abdominal discomfort?

_____ Abdominal bloating?

_____ Diarrhea?

_____ Constipation?

_____ History of anxiety?

_____ Depression?

PHYSICAL EXAMINATION:

_____ Results of a comprehensive physical examination.

_____ Any trigger point tenderness?

_____ Where?

LABORATORY STUDIES: (If performed)

_____ CBC?

_____ Sedimentation rate?

_____ Rheumatoid factor?

_____ ANA? T4? T3 uptake? TSH? X-rays? (Please provide copies of laboratory study reports.)

THERAPY:

_____ Trigger point injections?

_____ Stretch and spray therapy?

_____ Muscle stretching exercises?

_____ NSAID's? Amitriptyline? Prozac? Doxepin? Flexeril?

_____ Physical therapy?

_____ Psychotherapy? Etc.?

DISABILITY INFORMATION SHEET FOR HEADACHES

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ What is the character of the headache pain? (i.e. location, severity, frequency, throbbing or steady, etc.)

_____ Are there any visual or other prodrome? (Describe)

_____ When do the headaches occur?

_____ What factors make the headache better or worse?

_____ How long does the headache last?

_____ Does medication affect the headache?

_____ Is there a history of any psychiatric conditions such as depression, etc.?
(Describe)

_____ Any history of head trauma? (Describe)

_____ Are the headaches accompanied by fatigability?

_____ Irritability?

_____ Difficulty concentrating?

_____ Any history of seizures? (Describe)

_____ Any history of sinusitis or other upper respiratory conditions?

_____History of Glaucoma?

PHYSICAL EXAMINATION:

_____A complete neurological examination is needed.

_____ Any scalp/head tenderness?

_____Any bruits?

_____Any sign of autonomic dysfunction during the headaches?

LABORATORY STUDIES:

_____If performed, describe the results of: EEG?

_____CT Scan of the head?

_____X-rays of the head?

_____MRI of the head?

_____Other studies? (Please provide copies of reports.)

THERAPY:

_____Medications?

_____Relaxation techniques?

_____Massage?

_____Heat?

_____Exercise?

DISABILITY INFORMATION SHEET FOR HYPERTENSION

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

- _____ Date of onset of disease/diagnosis?
- _____ Symptoms referable to peripheral vascular disease?
- _____ Symptoms referable to cardiac disease?
- _____ Symptoms referable to neurological disease?
- _____ Symptoms referable kidney disease?
- _____ Other? (Please describe).

PHYSICAL FINDINGS:

- _____ Blood pressure readings (at work, at home, MD's office. Any significant difference between arms, etc.)?
- _____ Eyes (retinopathy)?
- _____ Peripheral vascular signs (pulses, skin changes, temperature of skin, ulcers, etc.)?
- _____ Kidneys (edema, itching)?
- _____ Heart (size, rhythm, murmurs, etc.)?
- _____ A neurological examination of effected areas?

_____ Other? (Please describe in detail).

LABORATORY STUDIES:

_____ Blood pressure readings?

_____ Exercise testing?

_____ Electrocardiogram?

_____ Arteriograms (coronary, renal carotid, etc.)?

_____ Blood tests for renal function (BUN, creatinine, etc.)?

_____ CT scan of brain?

_____ Chest X-ray?

_____ 24 hour blood pressure recording?

_____ Visual acuity/visual fields, etc.?

_____ Echocardiogram?

_____ Renal function studies?

_____ Electroencephalogram?

_____ Renal perfusion studies?

_____ Other? (Please describe).

THERAPY: (Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy)

_____ Medications?

_____ Restrictions?

_____ Weight reduction?

_____ Salt restriction?

_____ Summaries of hospitalizations?

_____ Please explain the physiological basis for the restrictions?

_____ Operative summaries?

_____ Other? (Please describe in detail).

DISABILITY INFORMATION SHEET FOR INTESTINAL DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Date of onset of symptoms?

_____ Abdominal pain? (Please describe the nature, location, severity, etc.)

_____ Vomiting?

_____ Diarrhea?

_____ Constipation?

_____ Frequency and duration of exacerbations and remissions per year?

_____ Anorexia?

_____ Weight loss?

_____ Malaise?

_____ Fever?

_____ Flatulency?

_____ History of obstruction?

_____ History of Fistulas?

_____ Arthralgia?

_____ Family history of intestinal disease?

_____ Any foods which aggravate the symptoms? (Please describe).

PHYSICAL EXAMINATION:

_____ Results of a complete physical examination.

_____ Abdominal tenderness? (Location, degree, etc. Please describe in detail)

_____ Abdominal masses?

_____ Bowel sounds?

_____ Abdominal distention?

_____ Fever?

_____ Synovitis?

_____ Other?

LABORATORY STUDIES: (If performed)

_____ CBC?

_____ Serum chemistries?

_____ Radiographs, CT Scans, or MRI of the abdomen?

_____ Small bowel barium series?

_____ Barium enema?

_____ Endoscopic studies?

_____ Fecal fat analysis?

_____ Cultures?

_____ Stool parasites?

_____ Biopsies?

_____ Other? (Please provide copies of reports.)

THERAPY:

_____ Diet? (Please describe.)

_____ Vitamins?

_____ Medication? (Please describe in detail.)

_____ Surgical procedures? (Please provide copies of operative reports.)

_____ Hospitalizations (Please provide copies of discharge summaries.)

DISABILITY INFORMATION SHEET FOR IRRITABLE BOWEL SYNDROME

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Any abdominal pain? (Nature, duration, frequency, location, etc. Please describe in detail.)

_____ Constipation/diarrhea? (Nature, frequency, etc. Please describe in detail.)

_____ Any blood or mucus in stools?

_____ Flatulence?

_____ Nausea?

_____ Anorexia?

_____ Abdominal fullness?

_____ History of any affective disorders? (Please describe)

PHYSICAL EXAMINATION:

_____ Results of complete physical examination.

_____ Abdominal tenderness? (Location, degree, etc. Describe in detail)

_____ Bowel sounds?

_____ Abdominal masses?

LABORATORY STUDIES: (If performed)

_____ Barium enema?

_____ Sigmoidoscopy?

_____ Blood in stools?

_____ Stool for ova, parasites, etc?

_____ Stool culture?

_____ Psychosocial evaluation? (Please provide copies of reports)

THERAPY:

_____ Diet? (Dietary fiber, exclusion of dairy products, etc?)

_____ Medications?

_____ Vegetable mucilages?

_____ Psychotherapy?

_____ Other? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR LIVER DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ History of hepatitis?

_____ Jaundice?

_____ Weight loss or gain?

_____ Change in color of stool?

_____ Fatigability?

_____ Nausea?

_____ Vomiting?

_____ Abdominal pain?

_____ Oliguria?

_____ Hematemesis?

_____ Alcohol use? (How much?)

_____ Smoking history in pack years?

_____ History of liver or gall bladder disease in the family?

_____ History of drug use?

_____ Medications?

_____ Past occupational history in detail?

_____ Hobbies? (Describe)

_____ Residential characteristics?

_____ History of blood transfusion?

_____ Copies of Material Safety Data Sheets for substances used in the workplace?

_____ Results of last two industrial hygiene surveys of work place? (Please provide copies of reports).

_____ Personal protective equipment used in work place? (Describe)

PHYSICAL EXAMINATION:

_____ Results of current, complete physical examination.

_____ Hepatomegaly?

_____ Splenomegaly?

_____ Ascites?

_____ Jugular distention?

_____ Spider nevi?

_____ Palmar erythema?

_____ Telangiectases?

_____ Glossitis?

_____ Cheilosis?

_____ Jaundice?

_____ Evidence of pruritus?

_____Pleural effusion?

_____Purpura?

_____Tremor?

_____Dysarthria?

_____Asterixis?

_____Peripheral edema?

LABORATORY STUDIES: (If performed)

_____Results of serological tests for hepatitis A, B, & C.

_____Results of CBC including MCV & HCH.

_____Bilirubin, direct & indirect?

_____GGTP?

_____Albumin?

_____Globulin?

_____LDH?

_____Clearance tests?

_____Coagulation studies?

_____SGOT?

_____Alkaline Phosphatase?

_____Abdominal X-rays?

_____Barium Upper GI Studies?

_____Splenoportography and/or arteriography?

_____Hepatic scans?

_____ Esophagogastrosocopy?

_____ Liver biopsy? (Please provide copies of reports)

THERAPY:

_____ Medications?

_____ Other treatment?

_____ Immunotherapy?

_____ Respirator use?

_____ Restrictions? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR LUMBOSACRAL DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ What sort of activity or motion caused the initial attack?

_____ What activities help and which aggravate the symptoms?

_____ Describe the nature, location, and severity of the symptoms.

_____ Is there pain in the leg, ankle or foot? Is there radiation? Is it lancinating?

_____ Are the symptoms intermittent or constant?

_____ Are there paresthesias? (Where?)

_____ Do they change with coughing, sneezing, straining at stool?

_____ Is there pain when the patient arches backward?

_____ Other? (Please describe in detail.)

LABORATORY STUDIES:

_____ X-rays?

_____ Bone scan?

_____ CT Scan?

_____ Sedimentation rate?

- _____MRI?
- _____White blood count?
- _____Myelogram?
- _____Discography?
- _____EMG's?
- _____Venography?
- _____Other? (Please describe in detail.)

PHYSICAL FINDINGS:

- _____Patient's weight, height and body build?
- _____Toe walking? Rise up and down on toes 10-12 times?
- _____Describe the patient's gait.
- _____Heel walking?
- _____Alignment of the spine straight? Any scoliosis?
- _____Evidence of muscular atrophy? Circumference of thigh and calf?
- _____Location and severity of tenderness, if any? Is it diffuse or localized to one structure? Is the skin tender to pinch?
- _____Muscle weakness? If present, which muscles are involved? Is the weakness of the "voluntary release" or "give away" type?
- _____Presence and location of spasm, if present?
- _____Can the patient do deep knee bends on one side and then the other?
- _____Supine and sitting straight leg raising tests and other stretch tests, such as contralateral straight leg raising, etc. (Please describe the endpoint that is used.)

_____ Results of tests of sensation? (Touch, pinprick, position, temperature, and vibration) Location and distribution Is it dermatomal? Is it “stocking”?

_____ Result of congruency tests? (E.g., Axial loading, rotation, sitting vs. Supine straight leg raising, distraction, Hoover, voluntary release, etc.)

_____ Deep tendon reflexes?

_____ Babinski?

_____ Other? (Please describe in detail.)

OTHER STUDIES:

Because environmental, behavioral and social factors can play an extremely important role in the pathogenesis of lumbosacral disorders, clarification of the extent of emotional disturbance, if any, created by this disorder may be needed by means of a psychosocial assessment by a psychiatrist.

THERAPY: *(Frequency and dosage should be described. Describe response to therapy and the patient’s compliance with therapy).*

_____ Bed rest?

_____ TENS?

_____ Physical Therapy?

_____ Psychotherapy?

_____ Exercises?

_____ Weight reduction? (if indicated)

_____ Medications? (i.e., anti-inflammatory, analgesics, steroids, muscle relaxants, etc.)

_____ Pain clinic?

_____ Traction?

_____ Steroid injections?

_____ Manipulation?

_____ Surgical procedures? (Please include operative reports).

_____ Braces and/or corsets?

_____ Restrictions?

_____ Hospitalization(s). (Please include reports).

_____ Please explain the physiological basis for these restrictions.

_____ Back School?

_____ Other? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR LYME DISEASE

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ History of tick bite? (When?)

_____ Any skin rash(es)? (Please describe)

_____ Malaise?

_____ Fatigue?

_____ Fever?

_____ Chills?

_____ Headache?

_____ Stiff neck?

_____ Backache?

_____ Myalgia?

_____ Arthralgia? (If so, what joints were involved and what is the duration of the episodes?)

_____ Nausea?

_____ Vomiting?

_____ Cardiac symptoms?

_____ Sleep disturbances?

_____ Difficulty in concentration?

_____ Memory impairment?

_____ Depression?

_____ Paresthesia?

_____ Any paralysis? (Please describe in detail.)

_____ Dizziness?

_____ Vertigo?

_____ Changes in hearing?

_____ Visual problems?

PHYSICAL EXAMINATION:

Results of a complete physical examination with particular attention to:

- Skin--Any lesions? (Please describe)
- Chest--Areas of dullness? Increased or decreased breath sounds? Friction rubs, rales, rhonchi, wheezes, etc.?
- Cardiac--Size, apical impulse, rate, rhythm, character of sounds, murmurs, S3, etc? Nature of venous pulse waves?
- Musculoskeletal System--Joint contours? Location and severity of tenderness? Cysts? Crepitation? Effusion? Erythema? Range of motion of affected joints?
- Neurological System--Mental status exam? Cranial nerves? Sensory or motor changes? Test of coordination? Ataxia? Pathological reflexes or signs?

LABORATORY STUDIES: (If performed, please provide copies of report.).

_____ CBC?

_____ Sedimentation rate?

_____ ANA?

_____Rheumatoid factor?

_____Serologic tests?

_____Immunoglobulin levels?

_____X-rays?

_____MRI?

_____Electrocardiogram?

_____Echocardiogram?

_____Other?

THERAPY:

_____Medications? (Please specify)

_____Other? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR MULTIPLE SCLEROSIS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ History of diplopia?

_____ Blurred vision?

_____ Loss of vision?

_____ Sensory symptoms? (Describe location, nature, etc.)

_____ Speech difficulties?

_____ Gait disturbances?

_____ Urinary urgency, hesitancy or incontinence?

_____ Disequilibrium?

_____ Fatigue?

_____ Motor weakness? (Please describe)

_____ Disturbances of coordination? (Please describe).

PHYSICAL FINDINGS:

_____ Results of a complete physical examination with emphasis on the nervous system.

_____ Pallor of the optic disk?

_____ Internuclear ophthalmoplegia?

_____ Cerebellar ataxia?

_____ Dysarthria?

_____ Hyperreflexia?

_____ Spasticity?

_____ Weakness?

_____ Lhermitte's sign?

_____ Nystagmus?

LABORATORY STUDIES: (If performed)

_____ MRI?

_____ CT Scan?

_____ CSF studies?

_____ Somatosensory evoked responses.

_____ Visual evoked responses?

_____ Auditory evoked responses?

_____ Other? (Please provide copies of reports.)

THERAPY:

_____Medications? (Please describe.)

_____Supportive? (Please describe.)

_____Hospitalizations? (Please provide copies of discharge summaries.)

CLINICAL COURSE:

Describe in detail the clinical course of this condition in this patient, e.g. frequency and duration of relapses and remissions, etc.

DISABILITY INFORMATION SHEET FOR MUSCULOSKELETAL DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ Location, distribution and nature (e.g., sharp, dull, intermittent, constant, etc.) of the pain.

_____ Any stiffness of the joint? When in the day is it better and when is it worse?

_____ What movements and activities produce or aggravate the pain?

_____ Nature and distribution of the radiation, if present.

_____ Any locking of the joint?

_____ History of previous injury to the joint.

_____ Any history of swelling or redness of the joint?

_____ History of weakness?

_____ Parasthesias? If so, distribution, nature, etc.

_____ Other? (Please describe in detail.)

LABORATORY STUDIES:

_____ X-rays?

_____ Arthroscopy?

- _____ CT Scan?
- _____ Sedimentation rate?
- _____ MRI?
- _____ ANA?
- _____ Bone scan?
- _____ Rheumatoid factor?
- _____ Arthrocentesis?
- _____ Arthrograms?
- _____ Other? (Please describe in detail.)

PHYSICAL FINDINGS:

- _____ Bone and soft tissue contours?
- _____ McMurray's (special test)?
- _____ Deformity?
- _____ Lachmann's (special test)?
- _____ Location and severity of tenderness.
- _____ Lateral pivot (special test)?
- _____ Cysts?
- _____ Yergason's sign (special test)?
- _____ Muscle spasm?
- _____ Effusion?
- _____ Tests of stability?
- _____ Peripheral pulses?

_____ Range of motion (both active and passive) in degrees as appropriate for the joint in question (abduction, adduction, flexion, extension, internal rotation and external rotation. Also, pronation and supination for the elbow).

_____ Muscle power (in the same planes of direction as for range of motion for the joint in question). If muscle weakness is present, is it of the “voluntary release” or “give away” type?

_____ Evidence of muscle atrophy? Measure the circumference of the appropriate limb(s).

_____ Neurological examination as appropriate (Sensation, deep tendon reflexes, pathological reflexes, etc.)

_____ Stance and gait

_____ Other? (Please describe in detail.)

THERAPY: *(Frequency and dosage should be described. Describe response to therapy and the patient’s compliance with therapy.)*

_____ Splints?

_____ Weight reduction?

_____ Braces?

_____ Exercises?

_____ Medications? (e.g., anti-inflammatory, analgesics, steroids, etc.)

_____ Hospitalization(s) (Please include copies of reports).

_____ Physical Therapy?

_____ Restrictions?

_____ Operative procedures? (Please include copies of reports).

_____ Please explain the physiological basis for the restrictions.

_____ Manipulation?

_____ Other? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR NECK DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ What sort of activity or motion caused the initial attack?

_____ What activities help and which aggravate the symptoms?

_____ Describe the nature, location, and severity of the symptoms (e.g., pain and stiffness).

_____ Is there pain in the shoulder or arm? Is there radiation?

_____ Are they intermittent or constant?

_____ Is there any paresthesias? Where? Is the distribution dermatomal?

_____ Do they change with coughing, sneezing, or straining at stool?

_____ Other? (Please describe in detail.)

LABORATORY STUDIES:

_____ X-rays?

_____ EMG's?

_____ CT Scan?

_____ Bone Scan?

_____MRI?

_____Sedimentation rate?

_____Myelogram?

_____Other? (Please describe in detail.)

PHYSICAL FINDINGS:

_____Range of motion of the cervical spine in degrees. (Rotation, flexion and extension, lateral flexion, both active and passive).

_____Muscular weakness? Which muscles are involved? Is the weakness of the “give away” or “voluntary release” type?

_____Location and severity of tenderness, if any? Is it diffuse or limited to anatomic structures?

_____Results of tests of sensation? (Touch, pinprick, position, vibration, and temperature). Location and distribution. Is it dermatomal?

_____Presence and location of spasm, if present?

_____Deep tendon reflexes?

_____Crepitation?

_____Cranial nerves?

_____Spurling’s test?

_____Babinski?

_____Evidence of muscular atrophy? Circumference of upper arm and forearm?

_____Hoffman?

_____Other?

THERAPY: *(Frequency and dosage should be described. Describe response to therapy and the patient’s compliance with therapy.)*

_____Bedrest?

_____Pain clinic?

_____Physical therapy?

_____TENS?

_____Traction?

_____Surgical procedure(s). Please include the operative report(s).

_____Cervical collar?

_____Hospitalization(s)? (Please include the report).

_____Manipulation?

_____Restrictions? (workplace, recreational, at home)

_____Medication? (e.g., anti-inflammatory, analgesics, steroids, muscle relaxants, etc.)

_____Please explain the physiological basis of the restrictions.

_____Steroid injections?

_____Other? (Please describe in detail.)

**DISABILITY INFORMATION SHEET
FOR OCCUPATIONAL ASTHMA/REACTIVE
AIRWAY DISEASE**

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy on this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ When did the respiratory symptoms begin?

_____ Describe their nature.

_____ Did the symptoms develop after starting a new job or after new materials were introduced?

_____ Did the symptoms develop within minutes of specific activities or exposure at work?

_____ Is there a history of a high level acute exposure? Do delayed symptoms occur? Describe them.

_____ Do symptoms occur less frequently or not at all on days away from work and on vacation?

_____ Do symptoms occur more frequently on returning to work?

_____ Is there any history of atrophy? Describe this.

_____ Is there a smoking history? Is there an occupational history?

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the respiratory system.

LABORATORY: (If performed)

_____ Dynamic pulmonary function tests with and without bronchodilators? Static pulmonary function tests including DLCO.

_____ Inhalation challenge testing?

_____ Results of skin testing?

_____ RAST tests? (Please provide copies of reports.)

_____ Results of peak expiratory flow rates while at work and away from work.

_____ Copies of MSDS for substances used at work?

_____ Results of recent industrial hygiene surveys for the workplace.

THERAPY:

_____ Medications?

_____ Respirator use?

_____ Restriction? (Please describe.)

DISABILITY INFORMATION SHEET FOR OCCUPATIONAL LUNG DISEASE

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ When did the respiratory symptoms begin? Describe their nature. (i.e. wheezing, cough, chest tightness, chest pain, shortness of breath, etc.)
Please describe their frequency and severity?

_____ Did the symptoms develop after starting a new job or after new materials were introduced?

_____ Did the symptoms develop within minutes of specific activities or exposure at work?

_____ Is there a history of a high level acute exposure?

_____ Do delayed symptoms occur? (Please describe.)

_____ Do symptoms occur less frequently or not at all on days away from work and on vacation?

_____ Do symptoms occur more frequently on returning to work?

_____ Any history of atopy? Describe.

_____ Smoking history?

_____ Occupational history?

PHYSICAL EXAMINATION:

Results of a complete physical examination with emphasis on the respiratory system.

LABORATORY STUDIES: (If performed)

_____ Dynamic pulmonary function tests with and without bronchodilator?

_____ Static pulmonary function tests including DLCO.

_____ Inhalation challenge testing?

_____ Results of skin testing?

_____ RAST tests?

_____ Results of peak expiratory flow rates while at work and away from work.

_____ Copies of MSDS for substances used at work?

_____ Results of recent industrial hygiene surveys for the workplace.

THERAPY:

_____ Medications?

_____ Respirator use?

_____ Restrictions? (Please describe)

_____ Hospitalizations and consultations? (Please provide copies of discharge summaries and consultative reports.)

DISABILITY INFORMATION SHEET FOR OCCUPATIONAL SKIN DISEASE

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Please describe the chronological sequence of events surrounding the onset of the skin disease, its subsequent clinical course and associated work activities of the applicant.

_____ Provide a description of the skin lesions and their initial anatomic location(s) and spread to other body sites.

_____ Please describe the disability caused by the skin disease.

_____ Please identify all relevant work exposures.

_____ Are similar skin lesions present in co-workers?

_____ What has been the response to previous medical treatment.

_____ Did the skin disease improve while the applicant was performing modified work activities or not working?

_____ Is there any history of personal or family atopy or allergies?

_____ Was there any antecedent skin disease or reactions?

PHYSICAL EXAMINATION:

_____What is the morphological appearance of the skin lesions?

_____What is the anatomical distribution?

LABORATORY STUDIES: (If performed)

_____Results of patch testing. (Please provide copies of reports.)

_____Results of biopsies. (Please provide copies of reports.)

THERAPY:

_____Medications?

_____Engineering controls in the workplace?

_____Protective clothing?

_____Gloves?

_____Barrier creams?

_____Skin hygiene and cleansing?

_____Response to therapy? (Please describe.)

DISABILITY INFORMATION SHEET FOR PHLEBITIS & VENOUS INSUFFICIENCY

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Any history of thrombophlebitis?

_____ Number and dates of episodes?

_____ Any history of pulmonary embolism?

_____ Number and dates?

_____ Any history of heart disease? (Please describe.)

_____ History of edema of the lower extremity?

PHYSICAL EXAMINATION:

_____ Height and weight?

_____ Edema? How much?

_____ Varicosities? (Please describe.)

_____ Any skin changes (e.g. thin, shiny, atrophic, etc.)

_____ Eczema? Number, size & location of ulcerations?

LABORATORY STUDIES: (If performed)

_____ Plethysmography?

_____Ultrasound?

_____Venogram? (Please provide copies of reports.)

THERAPY:

_____Weight reduction (if indicated).

_____Medications?

_____Elastic stockings?

_____Bed rest?

_____Elevation of the leg(s)?

_____Unna cast?

_____Surgical procedures? (Please include copies of operative reports.)

_____Hospitalization(s)? (Please include copies of discharge summaries.)

_____Restrictions?

DISABILITY INFORMATION SHEET FOR PSYCHIATRIC DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ Date of onset of disease?

_____ Drug or alcohol abuse history?

_____ Symptoms which fulfill the diagnostic criteria of DSM-III-R?

_____ Other? (Please describe in detail.)

PHYSICAL FINDINGS:

_____ Signs that fulfill the diagnostic criteria of DSM-III-R?

_____ Other physical findings that may affect the ability to work or recovery from the psychiatric condition.

_____ Other? (Please describe in detail.)

LABORATORY STUDIES:

_____ Personality testing?

_____ Neuropsychiatric testing?

_____ Tests of cognitive function?

_____ Intellectual testing/

_____ Educational evaluation?

_____ Other? (Please describe in detail.)

THERAPY: *(Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.)*

_____ Medications?

_____ Prognosis?

_____ Psychotherapy?

_____ Restrictions?

_____ Summaries of hospitalizations?

_____ Work evaluation reports?

_____ Rehabilitation progress notes?

_____ Other? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR RENAL DISEASE

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Any history of renal disease (e.g. infections, vascular, nephrotoxicity, immune, metabolic, congenital, obstructive uropathy, etc.? (Please describe in detail.)

_____ Any weakness?

_____ Easy fatiguability?

_____ Headaches?

_____ Anorexia?

_____ Nausea and vomiting?

_____ Polyuria?

_____ Nocturia?

_____ Hypertension?

_____ Weight loss?

_____ Diarrhea?

_____ Itching?

_____ Paresthesia?

- _____ Seizures?
- _____ Visual difficulties?
- _____ Pulmonary edema?
- _____ Congestive heart failure?
- _____ Bleeding diatheses?

PHYSICAL EXAMINATION:

- _____ Pallor?
- _____ Hyperpnea?
- _____ Uremic breath?
- _____ Dehydration?
- _____ Excoriated skin?
- _____ Purpura?
- _____ Hypertension?
- _____ Retinopathy?
- _____ Cardiac enlargement?
- _____ Pulmonary edema?
- _____ Peripheral neuropathy?

LABORATORY STUDIES: (If performed)

- _____ CBC?
- _____ Bleeding time?
- _____ Urinalysis?
- _____ BUN?

- _____ Creatinine?
- _____ Uric acid?
- _____ Serum sodium?
- _____ Potassium?
- _____ Calcium?
- _____ Magnesium?
- _____ Plasma bicarbonate?
- _____ Creatinine clearance?
- _____ Chest X-ray?
- _____ EKG?
- _____ CT Scan?
- _____ MRI?
- _____ Renal biopsy?
- _____ Other? (Please provide copies of reports).

THERAPY:

- _____ Diet?
- _____ Fluid intake?
- _____ Electrolyte replacement?
- _____ Medications?
- _____ Dialysis?
- _____ Kidney transplant?

_____ Other? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR RESPIRATORY DISEASE

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ Dyspnea? (Whether at rest, on exercise, how many blocks can be walked, how many stairs walked up, orthopnea?)

_____ Cough? (Productive vs. non-productive, in the morning, when lying down, hemoptysis, etc.)

_____ Pneumothorax, pleurisy, pneumonia, etc.?

_____ Chest pain? (When, where, what makes it better or worse?)

_____ Wheezing? (Indicate time of day, week, etc.)

_____ Smoking history? (How many years and number of packs a day?)

_____ Allergic history? (hay fever, eczema, etc.)

_____ Occupational history?

_____ Other? (Please describe in detail.)

PHYSICAL FINDINGS:

_____ Chest size, shape, and motion?

_____ Pheripheral edema?

_____ Cyanosis?

_____ Are friction rubs, rales, rhonchi, wheezing present? If so, do they clear up on coughing? Are there differences between lungs?

_____ Liver enlargement?

_____ Clubbing of fingers?

_____ Distended neck veins?

_____ Are there areas of dullness, increased or decreased breath sounds present?

_____ Other? (Please describe in detail.)

LABORATORY STUDIES:

_____ Chest X-rays?

_____ Exercise tests?

_____ Electrocardiogram?

_____ Arterial blood gases?

_____ Dynamic pulmonary function tests?

_____ CT Scan?

_____ FVC, FEV1, FEF 25-75?

_____ Inhalation challenge testing?

_____ Without bronchodilators?

_____ Skin testing?

_____ With bronchodilators?

_____ RAST tests?

_____ Methacholine challenge?

_____ Bronchoscopy?

- _____ Airway resistance?
- _____ Bronchograms?
- _____ Static pulmonary function tests?
- _____ Sputum cytology?
- _____ Lung volumes?
- _____ Pathology?
- _____ Compliance?
- _____ Closing volume?
- _____ Carbon monoxide diffusing capacity?
- _____ Other? (Please describe in detail.)

THERAPY: *(Frequency and dosage should be described. Describe response to therapy and the patient's compliance with therapy.)*

- _____ Medications? (bronchodilators, antibiotics, etc.)
- _____ Operative summaries?
- _____ Oxygen requirements?
- _____ Restrictions?
- _____ Chest physiotherapy?
- _____ Please explain the physiologic basis for your restrictions.
- _____ Summaries of hospitalization(s).
- _____ Other? (Please describe in detail.)

DISABILITY INFORMATION SHEET FOR RHEUMATOID ARTHRITIS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ When did symptoms first develop?

_____ Prodromal history malaise?

_____ Fever?

_____ Weight loss?

_____ Joint stiffness? (If joint stiffness is present, when is it worst? How long does it last? What helps it? What aggravates it? Which joints are involved?)

_____ Any history of vasomotor disturbances, e.g. paresthesia, Raynaud's phenomenon, etc.?

_____ Any family history of arthritis? (If so, please describe.)

PHYSICAL EXAMINATION:

_____ Specify which joints are involved and whether there is any tenderness, increased warmth, effusion, deformity and/or synovitis for each joint involved?

_____ Range of motion in degrees of each joint involved?

_____ Flexion contracture?

_____ Muscle atrophy?

_____Palmar erythema?

_____Any subcutaneous nodules?

_____Any dryness of mucus membranes?

_____Ocular changes?

_____Any peripheral neuropathy?

LABORATORY STUDIES: (If performed)

_____Rheumatoid Factor?

_____ANA?

_____Sedimentation Rate?

_____CBC?

_____X-rays and other imaging studies? (Please provide copies of reports)

THERAPY:

_____Braces and splints?

_____Exercises?

_____Physical modalities such as heat and cold? Medications?

PROGNOSIS:

Please describe the clinical course, e.g. progressive v. exacerbations and remissions.

DISABILITY INFORMATION SHEET FOR SEIZURE DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ When did the seizures start?

_____ Any family history of seizures?

_____ Any history of trauma at birth?

_____ History of alcohol or drug ingestion?

_____ Focal features? (Please describe).

_____ Any history of stroke, encephalitis or meningitis?

_____ Any abdominal pain, nausea, dizziness, behavioral disturbances or automatism? (Please describe in detail).

_____ Any deja vu phenomenon?

_____ Have the seizures been witnessed?

_____ Frequency per week of seizures?

_____ Duration of seizures?

_____ Any bowel or bladder incontinence during the seizure?

_____ Any postictal confusion or fatigue? (Please describe).

PHYSICAL EXAMINATION:

Results of a complete neurological examination.

LABORATORY STUDIES: (If performed)

_____ Results of EEG?

_____ MRI of the brain?

_____ CT Scan of the brain?

_____ Lumbar puncture? (Please provide copies of reports.)

THERAPY:

_____ Medications? (Please describe.)

_____ Hospitalizations? (Please provide copies of discharge summaries and admission history & physical examination summaries.)

DISABILITY INFORMATION SHEET FOR SYSTEMIC LUPUS ERYTHEMATOSUS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information is needed regarding:

HISTORY:

_____ Any history of fever?

_____ Anorexia?

_____ Weight loss?

_____ Malaise?

_____ Hair loss?

_____ Raynaud's phenomenon? (Fingertip lesions, e.g. periungual erythema, splinter hemorrhages, etc.?)

_____ Skin lesions? (Please describe.)

_____ Arthralgia?

_____ Conjunctivitis?

_____ Photophobia?

_____ Visual blurring?

_____ Pleurisy?

_____ Pneumonitis?

_____ Pericarditis?

- _____ Cardiac arrhythmias?
- _____ Abdominal pain?
- _____ Depression?
- _____ Convulsive disorders?
- _____ Neuropathies?
- _____ Renal disease?
- _____ How long have each of these been present?

PHYSICAL EXAMINATION:

Results of a complete physical examination.

LABORATORY STUDIES: (If performed)

- _____ ANA? (If positive, describe pattern.)
- _____ Sedimentation rate?
- _____ CBC?
- _____ Urinalysis?
- _____ Liver function studies?
- _____ Renal function studies?
- _____ Antiphospholipid antibodies?
- _____ EKG?
- _____ Chest X-ray?
- _____ Pulmonary function studies? (Please provide copies of reports.)

THERAPY:

_____ Medications? (Please describe.)

_____ Sun blocks and protective clothing, if photosensitive?

_____ Restrictions?

_____ Please describe the response to therapy.

DISABILITY INFORMATION SHEET FOR THORACIC SPINE DISORDERS

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information maybe needed regarding:

HISTORY:

_____ What sort of activity or motion caused the initial attack?

_____ Describe the nature, location and severity of symptoms.

_____ Are they intermittent or constant?

_____ Do they change with coughing, sneezing, straining at stool?

_____ What activities help and which aggravate symptoms?

_____ Is there radiation of the pain? Where? Is it lancinating?

_____ Is there paresthesia? Where?

_____ Is there pain when the patient arches backward?

PHYSICAL FINDINGS:

_____ Patient's weight, height and body build.

_____ Alignment of the spine straight? Any scoliosis?

_____ Location and severity of tenderness, if any? Is it diffuse or localized to one structure? Is the skin tender to pinch?

_____ Presence and location of spasm, if present?

_____ Range of motion of the spine in degrees.

_____ Results of congruency tests? (e.g. Axial loading, rotation, distraction, etc.)

_____ Results of tests of sensation? (Touch, pinprick, position, temperature and vibration.) Location and distribution. Is it dermatomal?

_____ Deep tendon reflexes?

_____ Babinski?

DISABILITY INFORMATION SHEET FOR VERTIGO

NAME: _____

To assist in submitting information regarding the history, current symptoms, physical findings, results of laboratory studies and therapy for this condition, you may use this information sheet to help when applying for Disability Retirement from the Office of Personnel Management. You may obtain this information from your treating physician(s). Specific information may be needed regarding:

HISTORY:

_____ When did the vertigo start?

_____ Is the patient spinning or are things spinning around him?

_____ In which direction does the spinning occur?

_____ What is the frequency of vertiginous episodes?

_____ What is their duration?

_____ What helps and what aggravates these episodes?

_____ Does the patient fall with these episodes?

_____ Does nausea accompany the vertigo?

_____ Any tinnitus?

_____ Hearing loss?

_____ Any vomiting?

_____ Any URI's, trauma, inflammatory processes, etc. prior to developing vertigo?

_____ Any family history of hearing disorders?

_____ Any history of cardiovascular disease or hypertension?

_____ Any history of neurological disorders?

_____ Any ear fullness, ear pressure, ear pain, etc?

_____ Any otorrhea?

PHYSICAL EXAMINATION:

_____ Complete ENT examination?

_____ Complete cardiovascular system examination?

_____ Complete neurological examination?

_____ Any spontaneous nystagmus? (If present, please describe.)

_____ With 20 diopter glasses? Describe the gait.

_____ Romberg test results?

_____ Heel to toe walking?

_____ Any positional nystagmus, e.g. Dix Hallpike test?

LABORATORY STUDIES: (If performed.)

_____ Electronystagmography?

_____ X-rays?

_____ MRI?

_____ Brain stem auditory evoked response?

_____ CT Scan?

_____ Audiogram?

_____ Blood chemistries?

_____ Hematological studies?

_____ Sedimentation rate?

_____ ANA? (Please provide copies of reports.)

THERAPY:

_____ Medications?

_____ Diet?

_____ Exercises?

_____ Operative procedures?

_____ Hospitalization(s)? (Please provide copies of hospitalization discharge summaries, operative reports, etc.)